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Your Medicare Handbook

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HOW TO USE YOUR MEDICARE HANDBOOK

This is *Your Medicare Handbook*. It tells you what Medicare is and how it works. Keep the handbook where you can find it. Then, when you need medical care, you can use the handbook to find out whether the services you need are covered by Medicare and how Medicare payment will be made. If you need information on a specific subject, use the alphabetical index at the back of the handbook.

Medicare will help pay for many of your health care expenses, but not all of them. You should know in advance what expenses Medicare does not cover. On pages 46 and 47 there is a list of the services and supplies Medicare cannot pay for and some that Medicare can pay for only under certain conditions.

Page 52 tells you how to submit your medical insurance claims, and beginning on page 55 there is an address list showing where to send your claims.

Page 44 tells you what to do if you think there has been a mistake in a Medicare decision or the amount of payment.

Page 45 describes prepayment plans (e.g., HMOs).

As you read the handbook, you will see stars (*) by some words. A star means there is a footnote at the bottom of the page that will give you additional information.

A supplement to this handbook explains coverage and payment for kidney dialysis and kidney transplant services. If you are receiving these services, please contact any Social Security office for a copy of the supplement.

Most of the information in the handbook will be correct for a long time, but some may change. We will try to keep you informed as changes occur.

However, if you have questions or can't find information you need in the handbook, call a Social Security office or your Medicare carrier.

Local Social Security offices are listed in the telephone directory under "Social Security Administration." Medicare carriers are listed on pages 56-64 of this handbook.

WHAT IS MEDICARE

Medicare is a Federal health insurance program for people 65 or older and certain disabled people. It is run by the Health Care Financing Administration. Local Social Security Administration offices take applications for Medicare and provide information about the program.

Medicare has two parts—*hospital insurance* and *medical insurance. Hospital insurance* can help pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care. *Medical insurance* can help pay for medically necessary doctors' services, outpatient hospital services, and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare. Medical insurance also can pay for home health services.

Medicare does not pay the full cost of some covered services. The amounts Medicare does not pay are described in this handbook. As general health care costs rise, these amounts may increase. If they do, we will notify you. For people with very low incomes, the Medicaid program in their State may pay the amounts Medicare does not pay and may pay some health care expenses not covered by Medicare. For information about private health insurance to supplement Medicare, see page 51.

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Medicare payments are handled by private insurance organizations under contract with the Government. Organizations handling claims from hospitals, skilled nursing facilities, and home health agencies are called *intermediaries*. Organizations handling claims from doctors and other suppliers of services covered under the medical insurance part of Medicare are called *carriers*.

YOUR MEDICARE CARD

Be sure you keep the Medicare health insurance card we sent you. The card shows the Medicare protection you have (hospital insurance, medical insurance, or both) and the date your protection started. If you don't have both parts of Medicare, see page 48 to find out how you can get the part you don't have.

The card also shows your health insurance claim number. The claim number has 9 digits and a letter. In some cases, there will be another number after the letter. Be sure to put your full claim number on all Medicare claims and correspondence. If a husband and wife both have Medicare, they get separate cards and different claim numbers. Each must use the exact name and claim number shown on his or her card.

Important things to remember

- Always show your Medicare card when you receive services that Medicare can help pay for.
- Always write your health insurance claim number (including the letter) on any bills you send in and on any correspondence about Medicare. Also, have your Medicare card available if you make a telephone inquiry.

- Carry your card with you whenever you are away from home. If you ever lose it, immediately ask the people in any Social Security office to get you a new one.
- Do not use your Medicare card before the effective date shown on your card.
- Medicare cards made of metal or plastic, which are sold by some manufacturers, are not a substitute for your officially issued Medicare card.

WHO CAN PROVIDE SERVICES OR SUPPLIES UNDER MEDICARE

Health care organizations and professionals providing services to Medicare beneficiaries must meet all licensing requirements of State or local health authorities. The organizations and persons shown below also must meet additional Medicare requirements before payments can be made for their services:

- Hospitals
- Skilled nursing facilities
- Home health agencies
- Hospice programs
- Independent diagnostic laboratories and organizations providing X-ray services
- Organizations providing outpatient physical therapy and speech pathology services
- Facilities providing outpatient surgical services
- Comprehensive outpatient rehabilitation facilities
- Ambulance firms
- Chiropractors
- Independent physical therapists (those who furnish services in your home or in their offices)

- Facilities providing kidney dialysis or transplant services
- Rural health clinics

All hospitals, skilled nursing facilities, and home health agencies participating in the Medicare program must comply with title VI of the Civil Rights Act, which prohibits discrimination because of race, color, or national origin.

Except for certain situations described later in this handbook, Medicare cannot pay for care you get from a non-participating hospital, skilled nursing facility, home health agency, or hospice.

You should always make sure that the persons or organizations providing services are approved for Medicare payments. If you are not sure, ask them.

SOME IMPORTANT RULES

Under the law, Medicare does not cover custodial care or care that is not "reasonable and necessary" for the diagnosis or treatment of an illness or injury.* These rules are explained below.

***Waiver of liability**

There is a provision in the Medicare law that says you will not be held responsible for paying for such care if you could not reasonably be expected to know it was not covered by Medicare. This provision is called "waiver of beneficiary liability." Waiver applies only when the care is not covered because it was custodial care or was not reasonable or necessary for diagnosis or treatment. Also, the waiver provision does not apply to medical insurance claims unless the doctor or other person who furnished the services agreed to payment under the assignment method (see page 25).

Care that is custodial
Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. Even if you are in a participating hospital or skilled nursing facility or you are receiving care from a participating home health agency, Medicare does not cover your care if it is mainly custodial.

Care that is not reasonable and necessary
If a doctor places you in a hospital or skilled nursing facility when the kind of care you need could be provided elsewhere, your stay would not be considered reasonable and necessary. So Medicare could not cover your stay. If you stay in a hospital or skilled nursing facility longer than you need to be there, Medicare payments would end when further inpatient care is no longer reasonable and necessary.

If a doctor (or other practitioner) comes to treat you or you visit him or her for treatment more often than is the usual medical practice in your area, Medicare would not cover the "extra" visits unless there are medical complications. Medicare cannot cover more services than are reasonable and necessary for your treatment. Any decision of this kind is always based on professional medical advice.

Peer Review Organizations
Peer Review Organizations (PROs) are groups of practicing doctors who are paid by the Federal government to review hospital care of Medicare pa-

tients. There are PROs in each State to help Medicare decide whether inpatient care is reasonable and necessary, is provided in the appropriate setting, and meets the standards of quality accepted by the medical profession.

In addition, PROs respond to requests for review of hospital decisions or reconsideration of PRO decisions made about hospital stays. They also investigate individual patient complaints.

If you feel that you have been refused admission to a hospital improperly or that you are being forced to leave the hospital too soon, ask for a written explanation of the decision. Medicare regulations require that such a written notice must fully explain how you can appeal the decision and it must give you the name, address, and phone number of the Peer Review Organization where your appeal or your request for review can be submitted.

Fraud and abuse hot line

If you have reason to believe that a doctor, hospital, or other provider of health care services is performing unnecessary or inappropriate services, or is billing Medicare for services you did not receive, a toll-free Hot Line has been installed by the Inspector General so that you may report any evidence of such fraud, waste, or abuse of the Medicare program.

The toll-free number is: *(800) 368-5779.* In Maryland call (800) 638-3986. If you prefer to send your complaints in writing, the adddress is: HHS, OIG, Hot Line, P.O. Box 17303, Baltimore, Maryland 21203-7303.

Do not call the Hot Line for Medicare policy questions or questions about delayed claims or payments.

HOSPITAL INSURANCE

YOUR MEDICARE HOSPITAL INSURANCE

Medicare hospital insurance helps pay for four kinds of care. The four kinds of care are (1) inpatient hospital care, (2) medically necessary inpatient care in a skilled nursing facility after a hospital stay, (3) home health care, and (4) hospice care.

There is a limit on how many days of hospital or skilled nursing facility care Medicare can help pay for in each benefit period.* But, your hospital insurance protection is renewed every time you start a new benefit period.

Medicare hospital insurance will pay for most but not all of the services you receive in a hospital or skilled nursing facility or from a home health agency or hospice program. There are covered services and non-covered services under each kind of care. Covered services are services and supplies that hospital insurance can pay for.

***Benefit period**

A benefit period is a way of measuring your use of services under Medicare hospital insurance. Your first benefit period starts the first time you enter a hospital after your hospital insurance begins. A benefit period ends when you have been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge). There is no limit to the number of benefit periods you can have for hospital or skilled nursing facility care. However, special limited benefit periods apply to hospice care (see page 20).

You do not have to send us any bills for care you receive from a participating hospital, skilled nursing facility, home health agency or hospice. Medicare will pay its share of the costs directly to the place where you received the care.

Whenever a hospital, skilled nursing facility, or home health agency sends Medicare a hospital insurance claim for payment, you will get a *Medicare Benefit Notice* that explains the decision made on the claim and shows what services Medicare paid for. If you have any questions about the notice, get in touch with the intermediary or call a Social Security office.

The Prospective Payment System

In 1983, Medicare began using a new system of paying most hospitals (except hospitals in Maryland and New Jersey). Under the Prospective Payment System hospitals now are paid fixed amounts based on the principal diagnosis for each Medicare hospital stay. In some cases, the Medicare payment will be more than the hospital's costs; in other cases, the payment will be less than the hospital's costs. In special cases, where costs for necessary care are unusually high, or the length of stay is unusually long, the hospital receives additional payment.

It is important to remember that this new system does *not* change your Medicare hospital insurance protection as described in this Handbook. It does not determine the length of your stay in the hospital or the extent of care you receive. The law requires hospitals to accept Medicare payments as payment in full, and hospitals are prohibited from billing the Medicare patient for anything other than applicable deductible and coinsurance amounts, plus any amounts due for non-covered items or services, such as television, private duty nurses, or custodial care.

WHEN YOU ARE A HOSPITAL INPATIENT

Medicare hospital insurance can help pay for inpatient hospital care if *all* of the following four conditions are met: (1) a doctor prescribes inpatient hospital care for treatment of your illness or injury, (2) you require the kind of care that can only be provided in a hospital, (3) the hospital is participating in Medicare, and (4) the Utilization Review Committee of the hospital or a Peer Review Organization does not disapprove your stay.

Hospital insurance can help pay for up to 90 days of medically necessary inpatient hospital care in each benefit period.

During 1986, from the 1st day through the 60th day in each benefit period, hospital insurance pays for all covered services *except the first $492.* This is called the hospital insurance deductible. The hospital may charge you the deductible only for your first admission in each benefit period. If you are discharged and then readmitted before the benefit period ends, you do not have to pay the deductible again.

From the 61st through the 90th day in a benefit period, hospital insurance pays for all covered services *except for $123 a day.* The hospital may charge you for the $123 a day.

Page 13 explains how hospital reserve days can help with your expenses if you ever need more than 90 days of inpatient hospital care in a benefit period.

Hospital insurance does *not* cover your doctor's services even though you receive them in a hospital. Doctors' services are covered under Medicare medical insurance. Page 22 tells how medical insurance helps with doctor bills.

Major services covered when you are a hospital inpatient
Medicare hospital insurance can pay for these services.

1 A semiprivate room (2 to 4 beds in a room)
2 All your meals, including special diets
3 Regular nursing services
4 Costs of special care units, such as an intensive care unit, coronary care unit, etc.
5 Drugs furnished by the hospital during your stay
6 Blood transfusions furnished by the hospital during your stay (see page 43 for information about coverage of blood)
7 Lab tests included in your hospital bill
8 X-rays and other radiology services, including radiation therapy, billed by the hospital
9 Medical supplies such as casts, surgical dressings, and splints
10 Use of appliances, such as a wheelchair
11 Operating and recovery room costs, including hospital costs for anesthesia services
12 Rehabilitation services, such as physical therapy, occupational therapy, and speech pathology services

Some services not covered when you are a hospital inpatient
Medicare hospital insurance cannot *pay for these services.*

1 Personal convenience items that you request such as a television, radio, or telephone in your room
2 Private duty nurses
3 Any extra charges for a private room unless it is determined to be medically necessary

Hospital inpatient reserve days

We said earlier that Medicare will help pay for your care in a hospital for up to 90 days in each benefit period. But what happens if you have a long illness and have to stay in the hospital for more than 90 days? Medicare hospital insurance includes an extra 60 hospital days you can use if this ever happens. These extra days are called reserve days. During 1986, hospital insurance pays for all covered services *except for $246 a day* for each reserve day you use. You are responsible for this $246. *Once you use a reserve day you never get it back.* Reserve days are *not* renewable like your 90 hospital days in each benefit period.

Since you have only 60 reserve days in your lifetime, you can decide yourself when you want to use them. After you have been in the hospital 90 days, you can use all 60 reserve days at one time if you have to stay in the hospital that long. But you don't have to use your reserve days right away if you don't want to. Maybe you have private insurance that can help pay your hospital bill if an illness keeps you in the hospital for more than 90 days. If you don't want to use your reserve days, you must tell the hospital in writing ahead of time. Otherwise, the extra days you need to be in the hospital will automatically be taken from your reserve days.

Care in a non-participating U.S. hospital

Usually, Medicare hospital insurance can help with your bills only if you are a patient in a participating hospital. But, hospital insurance can help pay for care in a qualified non-participating hospital if (1) you are admitted to the non-participating hospital for

emergency treatment and (2) the non-participating hospital is the closest one to get to that is equipped to handle the emergency. Under Medicare, emergency treatment means treatment that is immediately necessary to prevent death or serious impairment to health.

If the hospital elects to submit the claim for Medicare payment, Medicare will pay the hospital directly, except for any deductible or co-insurance amount. If the hospital does not submit the claim, you may submit the claim and receive payment. Any Social Security office can help you file the claim. Hospital insurance can pay for about two-thirds of the cost of a covered inpatient stay in a non-participating, qualified hospital.

Care in a psychiatric hospital

Hospital insurance can help pay for *no more than* 190 days of care in a participating psychiatric hospital in your lifetime. Once you have used these 190 days, hospital insurance cannot pay for any more care in a psychiatric hospital, even if you have some or all of your reserve days left.

Also, there is a special rule that applies if you are in a participating psychiatric hospital at the time your hospital insurance starts. Any Social Security office can give you information about this special rule.

Care in a foreign hospital

Medicare generally cannot pay for hospital or medical services outside the United States.* But, it can help pay for care in qualified Canadian or Mexican hospitals in three situations. These are: (1) you are in the U.S. when an emergency occurs and a Canadian or Mexican hospital is closer than the nearest U.S. hospital which can provide the emergency services you need, (2) you live in the U.S. and a Canadian or Mexican hospital is closer to your home than the nearest U.S. hospital which can provide the care you need, regardless of whether or not an emergency exists, and (3) you are in Canada traveling by the most direct route to or from Alaska and another State and an emergency occurs which requires that you be admitted to a Canadian hospital. (This provision does not apply if you are vacationing in Canada.)

When hospital insurance covers your inpatient stay in a Canadian or Mexican hospital, your medical insurance can cover necessary doctors' services and any required use of an ambulance. If the hospital does not submit the claim to Medicare, any Social Security office will help you get Medicare payment for the covered services you receive.

If you are planning to travel overseas, you may want to inquire about the availability of special short-term health insurance for foreign travel.

***United States**

Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the United States, along with the 50 States and the District of Columbia.

Care in a Christian Science sanatorium
Medicare hospital insurance can help pay for inpatient hospital and skilled nursing facility services you receive in a participating Christian Science sanatorium if it is operated, or listed and certified by, the First Church of Christ, Scientist, in Boston. You can get more information from any Social Security office.

INPATIENT CARE IN A SKILLED NURSING FACILITY

After you have been in a hospital, Medicare hospital insurance can help pay for inpatient care in a participating skilled nursing facility* if your condition still requires daily skilled nursing or rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility.

Hospital insurance can help pay for care in a skilled nursing facility if *all* of the following five conditions are met: (1) you have been in a hospital at least 3 days in a row (not counting the day of discharge)

***Skilled nursing facility**
A skilled nursing facility is a specially qualified facility which has the staff and equipment to provide skilled nursing care or rehabilitation services and other related health services. Most nursing homes in the United States are *not* skilled nursing facilities and many skilled nursing facilities are not certified by Medicare. In some facilities, only certain portions participate in Medicare. If you are not sure whether a facility or a particular portion participates in Medicare, ask someone at the facility or call a Social Security office.

before your transfer to a participating skilled nursing facility, (2) you are transferred to the skilled nursing facility because you require care for a condition which was treated in the hospital, (3) you are admitted to the facility within a short time (generally within 30 days) after you leave the hospital, (4) a doctor certifies that you need, and you actually receive, skilled nursing or skilled rehabilitation services on a daily basis, and (5) the facility's Utilization Review Committee or a Peer Review Organization does not disapprove your stay.

All five conditions must be met. But it's especially important to remember the requirement that you must need skilled nursing care or skilled rehabilitation services on a daily basis.

Skilled nursing care means care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist. The skilled nursing care and skilled rehabilitation services you receive must be based on a doctor's orders.

Hospital insurance *cannot* pay for your stay if you need skilled nursing or rehabilitation services only occasionally, such as once or twice a week, or if you do not need to be in a skilled nursing facility to get skilled rehabilitation services. And, hospital insurance *cannot* pay for your stay if the rehabilitation services are no longer improving your condition and could be carried out by someone other than a physical therapist or physical therapist assistant. Also, hospital insurance *cannot* pay for your stay if you are in a skilled nursing facility mainly because you need custodial care (see page 7).

When your stay in a skilled nursing facility is covered by Medicare, hospital insurance can help pay for up to 100 days in each benefit period, but *only* if you need daily skilled nursing care or rehabilitation services for that long.

If you leave a skilled nursing facility and are re-admitted within 30 days, you do not have to have a new 3-day stay in the hospital in order for your care to be covered. If you have some of your 100 days left and you need skilled nursing or rehabilitation services on a daily basis for further treatment of a condition treated during your previous stay in the facility, your care can be covered.

In each benefit period, hospital insurance pays for all covered services for the first 20 days you are in a skilled nursing facility. During 1986, for the 21st through 100th day, hospital insurance pays for all covered services *except for $61.50 a day.* You may be charged this amount by the skilled nursing facility.

Hospital insurance does *not* cover your doctor's services while you are in a skilled nursing facility. Medicare medical insurance covers doctors' services. Page 22 tells you how medical insurance helps with doctor bills.

Major services covered when you are in a skilled nursing facility
Medicare hospital insurance can pay for these services.

1 A semiprivate room (2 to 4 beds in a room)
2 All your meals, including special diets
3 Regular nursing services

4 Rehabilitation services, such as physical, occupational, and speech therapy
5 Drugs furnished by the facility during your stay
6 Blood transfusions furnished to you during your stay (see page 43 for information about coverage of blood)
7 Medical supplies such as splints and casts
8 Use of appliances such as a wheelchair

Some services not covered when you are in a skilled nursing facility
Medicare hospital insurance cannot *pay for these services.*

1 Personal convenience items that you request such as a television, radio, or telephone in your room
2 Private duty nurses
3 Any extra charges for a private room, unless it is determined to be medically necessary

HOSPICE CARE

Medicare hospital insurance can help pay for hospice care if *all* of the following three conditions are met: (1) a doctor certifies that a patient is terminally ill, (2) a patient chooses to receive care from a hospice* instead of standard Medicare benefits for the terminal illness, and (3) care is provided by a Medicare-certified hospice program.

***Hospice**
A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Special benefit periods apply to hospice care. Hospital insurance can pay for a maximum of two 90-day periods and one 30-day period. (If a patient still needs hospice services after hospice periods are exhausted, the hospice must continue care unless the patient no longer wants hospice services.)

During a hospice benefit period, Medicare pays the full cost of all covered services for the terminal illness. There are no deductibles or co-payments *except for part of the cost of outpatient drugs and inpatient respite care.* *The patient is responsible for 5 percent of the cost of outpatient drugs or $5 toward each prescription, whichever is less. For inpatient respite care, the patient pays 5 percent of the cost, up to a total of $492 (1986 amount) during a period that begins when a hospice plan is first chosen and ends 14 days after such care is cancelled.

While receiving hospice care, if a patient requires treatment for a condition not related to the terminal illness, Medicare continues to help pay for all necessary covered services under the standard Medicare benefit program.

***Respite care**

Respite care is a short-term inpatient stay which may be necessary for the patient in order to give temporary relief to the person who regularly assists with home care. Inpatient respite care is limited each time to stays of no more than five days in a row.

Services covered when provided by a hospice
Medicare hospital insurance can pay for these services:

1 Nursing services
2 Doctors' services*
3 Drugs, including outpatient drugs for pain relief and symptom management
4 Physical therapy, occupational therapy and speech-language pathology
5 Home health aide and homemaker services
6 Medical social services
7 Medical supplies and appliances
8 Short-term inpatient care, including respite care
9 Counseling

Some services not covered when you receive care from a hospice
Medicare hospital insurance cannot *pay for these services*

1 Treatments other than for pain relief and symptom management of your terminal illness
2 Five percent of the cost of outpatient drugs or $5 per prescription, whichever is less
3 Five percent of the cost of inpatient respite care, up to a total of $492 (1986 amount) during the period described on page 20.

*If the attending physician is not working for the hospice program, Medicare medical insurance will continue to pay for his or her services in the same way it usually pays for other doctors' services (see page 25).

YOUR MEDICARE MEDICAL INSURANCE

Medicare medical insurance can help pay for (1) doctors' services, (2) outpatient hospital care, (3) outpatient physical therapy and speech pathology services, (4) home health care, and (5) many other health services and supplies which are not covered by Medicare hospital insurance.

The following chapters will tell you more about these different kinds of care, the services that are and are not covered by medical insurance, and what part of your medical expenses Medicare can pay.

There is a basic payment rule under medical insurance. After you have $75 in *approved charges* (see page 23) for covered medical expenses in 1986, medical insurance generally will pay 80 percent of the *approved charges* for any additional covered services you receive during the rest of the year. You are responsible for the remaining 20 percent.

The first $75 in covered expenses is called the medical insurance *deductible*. You need to meet this $75 deductible only once during the year. The deductible can be met by any combination of covered expenses. You do not have to meet a separate deductible for each different kind of covered service you might receive.

APPROVED CHARGES

Medicare medical insurance payments are *not* based on your doctor's or supplier's* *current* charges. They are based on what the law defines as "reasonable charges"—the amounts approved by the Medicare carrier. Because of the way the approved amounts are determined and because of high rates of inflation in medical care prices, the charges approved are often *less* than the actual charges billed by doctors and suppliers. Medical insurance can pay only 80 percent of the approved charge, even if it is less than the actual charge.

The Medicare carrier for your area determines the approved charges for covered services and supplies under a procedure prescribed in the Medicare law. Each year, the carrier reviews the actual charges made by doctors and suppliers in your area during the previous year. Based on this review, new approved charges are put into effect about October 1 of each year.

Here's how approved charges are determined.

First, the carrier determines the *customary* charge (generally the charge most frequently made) by each doctor and supplier for each separate service or supply furnished to patients in the previous calendar year.

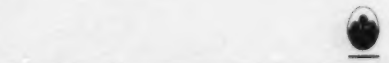
***Suppliers**

Suppliers are persons or organizations, other than doctors or health care facilities, that furnish equipment or services covered by medical insurance. For example, ambulance firms, independent laboratories, and organizations that rent or sell medical equipment are considered suppliers.

Next, the carrier determines the *prevailing* charge for each covered service and supply. The prevailing charge is the amount which is high enough to cover the customary charges in three out of every four bills submitted in the previous year for each service and supply. However, increases in prevailing charges for doctors' services are limited from year to year by an "economic index" formula which relates doctors' fee increases to the actual increases in the cost of maintaining their practices and to raises in general earnings levels.

Then, when a medical insurance claim is submitted, the carrier compares the actual charge shown on the claim with the customary and prevailing charges for that service or supply. The charge approved by the carrier will be either the customary charge, the prevailing charge, or the actual charge, *whichever is lowest*.

If your doctor's or supplier's actual charge is higher than the charge approved by the carrier, this does not necessarily mean that his or her charges are unreasonable. Usually, when the Medicare approved charge is lower than the actual charge, it's because your doctor or supplier recently raised his or her charge and it has not been in effect long enough to be included in Medicare's annual review. In other cases, of course, the actual charge may be higher than the approved charge because the doctor or supplier has higher charges for the particular service or supply than most other doctors and suppliers in your area. Or, the doctors in your area may have increased some of their charges by larger amounts than Medicare can recognize under the "economic index" formula in the law.



HOW MEDICAL INSURANCE PAYMENTS ARE MADE

There are two ways payments are made under Medicare medical insurance. The medical insurance payment can be made directly to the doctor or supplier. This payment method is called assignment. Or, the medical insurance payment can be made to you.

Assignment

The assignment method, in which the doctor or supplier receives the medical insurance payment directly from Medicare, can save you time and money. When the assignment method is used, the doctor or supplier agrees that his or her total charge for the covered service will be the charge approved by the Medicare carrier. Medicare pays your doctor or supplier 80 percent of the approved charge, after subtracting any part of the $75 deductible you have not met. The doctor or supplier can charge you *only* for the part of the $75 deductible you had not met and for the coinsurance, which is the remaining 20 percent of the approved charge. Of course, your doctor or supplier also can charge you for any services that Medicare does not cover.

Payment to you

If your doctor does *not* accept assignment, Medicare pays *you* 80 percent of the approved charge, after subtracting any part of the $75 deductible you haven't met. The doctor or supplier can bill you for his or her actual charge even if it is more than the charge approved by the carrier.

See page 52 to find out how to send in a claim for medical insurance payment.

Participating doctors and suppliers

Due to a change in the Medicare law, doctors and suppliers can now sign agreements to become *Medicare-participating* doctors or suppliers. This means that they have agreed in advance to accept assignment on *all* Medicare claims. Doctors and suppliers are given the opportunity to sign participation agreements each year.

The names and addresses of Medicare-participating doctors and suppliers are listed in the "Medicare-Participating Physician/Supplier Directory." This directory is available for review in all Social Security offices and State and area offices of the Administration on Aging. Also, this directory can be purchased from your Medicare carrier (see pages 56-64). In addition, Medicare-participating doctors and suppliers can display emblems or certificates which show that they accept assignment on all Medicare claims.

Explanation of Medicare Benefits notice

After you or the doctor or supplier sends in a medical insurance claim, Medicare will send you a notice called *Explanation of Medicare Benefits* to tell you the decision on the claim.

This notice shows what services were covered, what charges were approved, how much was credited toward your $75 yearly deductible, and the amount Medicare paid. Please examine the notice carefully. If you believe payment was made for a service or supply you didn't receive, or the payment is otherwise questionable, you may call the carrier that handled your claim. You will find the carrier's telephone number on the notice. Or, if you wish, you may take the notice to any Social Security office.

WHEN A DOCTOR TREATS YOU

Medicare medical insurance can help pay for covered services you receive from your doctor in his or her office, in a hospital, in a skilled nursing facility, in your home, or any other location in the U.S. Your medical insurance can also help pay for doctors' services you receive in connection with covered inpatient care in a Canadian or Mexican hospital. See page 15 to find out about care in Canadian and Mexican hospitals.

After you meet the $75 medical insurance deductible, medical insurance pays 80 percent of the approved amount for covered services you receive from your doctor.

Payment can be made either to you or to your doctor. Pages 25 and 26 describe the two payment methods.

Getting a second opinion before surgery
Sometimes your doctor will recommend surgery for the treatment of a medical problem. In some cases, surgery is unavoidable. But there is increasing evidence that many conditions can be treated equally well without surgery. Because even minor surgery involves some risk, we recommend that you get a second doctor's opinion to help you decide about surgery. Medical insurance will help pay for a second opinion in the same way it pays for other services by doctors.

Your own doctor is the best source for referral to another doctor. But, if you wish, you can call Medicare's Second Opinion Referral Center for the names and phone numbers of doctors in your area who provide second opinions. The toll-free number is 1-800-638-6833 (in Maryland 1-800-492-6603).

Major doctors' services covered by medical insurance
Medicare medical insurance can help pay for these services.

1 Medical and surgical services, including anesthesia
2 Diagnostic tests and procedures that are part of your treatment
3 Radiology and pathology services by doctors while you are a hospital inpatient

4 Other services which are ordinarily furnished in the doctor's office and included in his or her bill, such as:
   - X-rays you receive as part of your treatment
   - Services of your doctor's office nurse
   - Drugs and biologicals that cannot be self-administered
   - Transfusions of blood and blood components
   - Medical supplies
   - Physical therapy and speech pathology services

Some doctors' services not covered by medical insurance

Medicare medical insurance cannot *pay for these services.*

1 Routine physical examinations and tests directly related to such examinations
2 Routine foot care
3 Eye or hearing examinations for prescribing or fitting eyeglasses or hearing aids
4 Immunizations (except pneumococcal vaccinations or immunizations required because of an injury or immediate risk of infection)
5 Cosmetic surgery unless it is needed because of accidental injury or to improve the functioning of a malformed part of the body

Outpatient treatment of mental illness
Doctors' services you receive for outpatient treatment of a mental illness are covered under a special payment rule, *but the maximum amount medical insurance can pay for these services is $250 in a year.* The medical insurance payment would be less than $250 if charges for these services are used to meet part or all of your $75 deductible.

Chiropractors' services
Medical insurance helps pay for only one kind of treatment furnished by a licensed and Medicare-certified chiropractor. The *only* treatment that can be covered is manual manipulation of the spine to correct a subluxation that can be demonstrated by X-ray. Medical insurance does *not* pay for any other diagnostic or therapeutic services, including X-rays, furnished by a chiropractor.

Podiatrists' services
Medical insurance can help pay for any covered services of a licensed podiatrist, including the removal of plantar warts. Treatment of mycotic toenails (a fungus infection) is limited to once every 60 days unless the medical necessity for more frequent treatment is documented by the patient's physician.

Medical insurance generally does *not* cover routine foot care such as hygienic care; treatment for flat feet or other structural misalignments of the feet; and removal of corns, calluses, and most warts. But, medical insurance can help pay for routine foot care *if* you have a medical condition affecting the lower limbs (such as severe diabetes) which requires that such care be performed by a podiatrist or a doctor of medicine or osteopathy.

Dental care

Medical insurance can help pay for dental care *only if* it involves (1) surgery of the jaw or related structures, (2) setting fractures of the jaw or facial bones, or (3) services that would be covered when provided by a doctor. If you need to be hospitalized because of the severity of a dental procedure, Medicare can cover your hospital stay even if the dental care itself is not covered by Medicare.

Care in connection with the treatment, filling, removal, or replacement of teeth; root canal therapy; surgery for impacted teeth; and other surgical procedures involving the teeth or structures directly supporting the teeth generally are *not* covered.

Optometrists' services

If an optometrist provides examination services related to the condition of aphakia (absence of the natural lens of the eye), medical insurance will cover the optometrist's services.

OUTPATIENT HOSPITAL SERVICES

Medicare medical insurance helps pay for covered services you receive as an outpatient from a participating hospital for diagnosis or treatment of an illness or injury.

When you go to a hospital for outpatient services, be sure to show the people there your most recent *Explanation of Medicare Benefits* notice. From this form, they usually can tell how much of the $75 deductible you have met.

The hospital will always file the claim for medical insurance payment. Medical insurance pays the hospital 80 percent of the approved amount for the covered services you received, after subtracting any of the $75 deductible you have not met. The hospital will charge you for the part of the deductible you had not met plus 20 percent of the remaining approved amount.

If the hospital cannot tell how much of the $75 deductible you have met and the charge for the services you received is less than $75, the hospital may ask you to pay the entire bill. The amount you pay the hospital can be credited toward any part of the deductible you have not met, and any medical insurance payments due will be paid directly to you.

Under certain conditions, medical insurance can also help pay for emergency outpatient care you receive from a non-participating hospital.

Major outpatient hospital services covered by medical insurance

Medicare medical insurance helps pay for these services.

1 Services in an emergency room or outpatient clinic
2 Laboratory tests billed by the hospital
3 X-rays and other radiology services billed by the hospital
4 Medical supplies such as splints and casts
5 Drugs and biologicals which cannot be self-administered
6 Blood transfusions furnished to you as an out patient

Some outpatient hospital services not covered by medical insurance
Medicare medical insurance cannot *pay for these services.*

1 Routine physical examinations and tests directly related to such examinations
2 Eye or ear examinations to prescribe or fit eyeglasses or hearing aids
3 Immunizations (except pneumococcal vaccinations or immunizations required because of an injury or immediate risk of infection)
4 Routine foot care

OUTPATIENT PHYSICAL THERAPY AND SPEECH PATHOLOGY SERVICES

Medicare medical insurance can help pay for medically necessary outpatient physical therapy or speech pathology services. There are three different ways you can receive these services under medical insurance.

You may receive physical therapy or speech pathology services as part of your treatment in a doctor's office. In this case, the doctor must include the charge for the services in the bill. Medical insurance will pay 80 percent of the approved charges after the $75 deductible has been met. Either you or the doctor can submit the claim as described on page 52.

You may receive services directly from an independently practicing, Medicare-certified physical therapist in his or her office or in your home if such treatment is prescribed by a doctor. But, *the maximum amount medical insurance can pay for these services is $400 a year*. The medical insurance payment would be less than $400 if charges for these services are used to meet part or all of your $75 deductible. Either you or the physical therapist can submit the claim as described on page 52.

You may receive physical therapy or speech pathology services as an outpatient of a participating hospital or skilled nursing facility, or from a home health agency, clinic, rehabilitation agency, or public health agency approved by Medicare. The services must be furnished under a plan which your doctor sets up and periodically reviews. For outpatient speech pathology services, a speech pathologist can establish the plan for treatment. The organization providing services always submits the claim and may only charge you for any part of the $75 deductible you had not met, 20 percent of the remaining approved amount, and any noncovered services.

OUTPATIENT SURGICAL SERVICES

Some surgery can be performed safely on an outpatient basis, avoiding the need for an inpatient hospital stay. Medicare can pay for certain specified outpatient surgical procedures performed in a Medicare-certified outpatient surgical center. The center can be affiliated with a hospital or it can be in-

dependent, but it must provide only outpatient surgery services and must have an agreement with Medicare to do so.

If you and your surgeon choose to have your covered surgery performed in such a center, Medicare can pay the center 100 percent of the Medicare determined reimbursement rate for your use of the facility. Medicare also can pay 100 percent of your surgeon's and anesthesiologist's approved charge for services, including pre- and post-operative care, *if either or both accept assignment.* In this case you pay no deductible.

To find out if a particular procedure qualifies for these special payment rules, get in touch with your Medicare carrier.

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES

Under certain circumstances, Medicare can help pay for outpatient services you receive from a comprehensive outpatient rehabilitation facility (CORF). Covered services include physicians' services; physical, speech, occupational and respiratory therapies; counseling and other related services. You must be referred by a physician who certifies that you need skilled rehabilitation services, and you must go to the facility to receive the services. For covered services, other than mental health services, you are responsible only for the annual deductible and 20 percent of the facility's customary charges. The maximum Medicare can pay for outpatient psychiatric services is $250 a year for physicians' services and CORF services combined.

To find out if there is a participating comprehensive outpatient rehabilitation facility in your area, or for more information about CORF services, contact your nearest Social Security office.

OTHER SERVICES AND SUPPLIES COVERED BY MEDICAL INSURANCE

Medicare medical insurance also helps pay for other services and supplies which are described in this chapter. Medical insurance usually will pay 80 percent of the approved charges for these covered services and supplies after you have met the $75 deductible. Usually, when these services and supplies are furnished by a hospital, skilled nursing facility, or home health agency, it will make the claim for medical insurance payment. Otherwise, you or the supplier submits the claim. Page 52 tells you how medical insurance claims are submitted.

Independent laboratory services

Medical insurance can pay the full approved fee for covered diagnostic tests provided by independent laboratories that accept Medicare assignment. *If a doctor prescribes tests from a laboratory which does not accept assignment, Medicare cannot pay for the tests. So that Medicare can pay for your tests, be sure to ask the doctor about using a laboratory which accepts assignment.* Also, the laboratory must be certified by Medicare for the services you receive. Not all laboratories are certified by Medicare and some laboratories are certified only for certain kinds of tests. Your doctor can usually tell you which laboratories are certified and whether the tests he or she is prescribing from a certified laboratory are covered by medical insurance.

Ambulance transportation

Medical insurance can help pay for medically necessary ambulance transportation but *only* if (1) the ambulance, equipment, and personnel meet Medicare requirements, and (2) transportation in any other vehicle could endanger the patient's health.

Under these conditions, medical insurance can help pay for ambulance transportation from the scene of an accident to a hospital, from your home to a hospital or skilled nursing facility, between hospitals and skilled nursing facilities, or from a hospital or skilled nursing facility to your home. Also, if you are an inpatient in a hospital or skilled nursing facility which cannot provide a medically necessary service you need, medical insurance can help pay for round trip ambulance transportation to the nearest appropriate facility.

Medical insurance *cannot* pay for ambulance use from your home to a doctor's office.

Medical insurance usually can help pay for ambulance transportation only in your local area. But, if there are no local facilities equipped to provide the care you need, medical insurance will help pay for necessary ambulance transportation to the closest facility outside your local area that can provide the necessary care. If you choose to go to another institution that is farther away, Medicare payment still will be based on the reasonable charge for transportation to the closest facility.

Necessary ambulance services in connection with a covered inpatient stay in a Canadian or Mexican hospital (see page 15) can also be covered by medical insurance.

Prosthetic devices

Medical insurance helps pay for prosthetic devices needed to substitute for an internal body organ. These include heart pacemakers, Medicare-approved corrective lenses needed after a cataract operation, colostomy or ileostomy bags and certain related supplies, and breast prostheses (including a surgical brassiere) after a mastectomy. Medical insurance can also help pay for artificial limbs and eyes, and for arm, leg, back, and neck braces. Orthopedic shoes are covered *only* when they are part of leg braces and the cost is included in the orthopedist's charge. Dental plates or other dental devices are *not* covered.

Durable medical equipment

Medical insurance can help pay for durable medical equipment such as oxygen equipment, wheelchairs, home dialysis systems, and other medically necessary equipment that your doctor prescribes for use in your home. (A facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

The decision to rent or buy durable medical equipment is yours. However, the Medicare carrier that handles medical insurance claims in your area is required to review all claims for durable medical equipment. The carrier will notify you if it decides that rental or purchase would be less costly for you and the Medicare program.

When making your decision to rent or buy, ask your doctor about how long you will need the equipment and ask the equipment supplier or retailer for a comparison of the purchase price and the estimated rental payments for the period of time you expect to need the equipment.

Portable diagnostic X-ray services
Medical insurance helps pay the approved charges for portable diagnostic X-ray services you receive in your home if they are ordered by a doctor and *if* they are provided by a Medicare-certified supplier.

Medical Supplies
Medical insurance can also help pay for surgical dressings, splints, casts, and similar medical supplies ordered by a doctor in connection with your medical treatment. This does *not* include adhesive tape, antiseptics, or other common first-aid supplies.

Pneumococcal vaccine
Medical insurance will pay the full approved charges for pneumococcal vaccine and its administration. The $75 deductible does not apply to this service.

Hepatitis B vaccine
Medicare will help pay for hepatitis B vaccine administered to beneficiaries considered to be at high or intermediate risk of contracting the disease.

HOME HEALTH CARE UNDER MEDICARE

If you need part-time skilled health care in your home for the treatment of an illness or injury, Medicare can pay for covered home health visits furnished by a participating home health agency.* (A facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

Medicare can pay for home health visits only if *all* of the following four conditions are met: (1) the care you need includes part-time skilled nursing care, physical therapy, or speech therapy, (2) you are confined to your home, (3) a doctor determines you need home health care and sets up a home health plan for you, and (4) the home health agency providing services is participating in Medicare.

Once these conditions are met, either hospital insurance or medical insurance can pay for an unlimited number of home health visits. When you no longer need part-time skilled nursing care, physical therapy, or speech therapy, Medicare can continue to pay for home health visits *if* you need occupational therapy.

***Home health agency**

A home health agency is a public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy, in your home.

Medicare does *not* cover general household services, meal preparation, shopping, assistance in bathing or dressing, or other home care services furnished mainly to assist people in meeting personal, family, or domestic needs.

Home health services covered by Medicare
Medicare can *pay for these services.*

1 Part-time skilled nursing care
2 Physical therapy
3 Speech therapy
If you need part-time skilled nursing care, physical therapy, or speech therapy, Medicare can also pay for:

- Occupational therapy
- Part-time services of home health aides
- Medical social services
- Medical supplies
- Durable medical equipment (80% of approved cost)

Home health services not covered by Medicare
Medicare cannot *pay for these services*

1 Full-time nursing care at home
2 Drugs and biologicals
3 Meals delivered to your home
4 Homemaker services
5 Blood transfusions

Medicare pays the full approved cost of all covered home health visits. You may be charged only for any services or costs that Medicare does not cover.

The home health agency will submit the claim for payment. You don't have to send in any bills yourself.

MEDICARE COVERAGE OF BLOOD

Both hospital insurance and medical insurance can help pay for blood (whole blood or units of packed red blood cells), blood components, and the cost of blood processing and administration.

If you receive blood as an inpatient of a hospital or skilled nursing facility, hospital insurance can pay all of these blood costs, *except for any nonreplacement fees charged for the first 3 pints of whole blood or units of packed red cells in each benefit period.* The nonreplacement fee is the charge that some hospitals and skilled nursing facilities make for blood which is not replaced.

You are responsible for the nonreplacement fees for the first 3 pints or units of blood furnished by a hospital or skilled nursing facility. If you are charged nonreplacement fees, you have the option of either paying the fees or having the blood replaced. If you choose to have the blood replaced, you can either replace the blood personally or arrange to have another person or a blood assurance plan replace it for you. A hospital or skilled nursing facility *cannot* charge you for any of the first 3 pints of blood you replace or arrange to replace.

Medical insurance can help pay for blood and blood components you receive as an outpatient or as part of other covered services, *except for any nonreplacement fees charged for the first 3 pints or units received in each calendar year.* After you have met the $75 deductible, medical insurance pays 80 percent of the approved charges for blood starting with the fourth pint in a calendar year.

YOUR RIGHT OF APPEAL

If you disagree with a decision on the amount Medicare will pay on a claim or whether services you received are covered by Medicare, you always have the right to ask for a review of the decision.

For decisions on hospital stays, you can appeal a Medicare hospital insurance decision by asking for a Peer Review Organization review. (See page 7 for an explanation of "Peer Review Organizations.") Then, if you disagree with the Peer Review Organization's decision and the amount in question is $200 or more, you can request a hearing by an Administrative Law Judge of the Social Security Administration. Cases involving $2,000 or more can eventually be appealed to a Federal Court.

The appeals process for all other hospital insurance services (skilled nursing facility services, home health services, and hospice care) is somewhat different than the above. Requests for review of decisions involving these services should be submitted through the Medicare intermediary for each provider or through your local Social Security Office.

Under Medicare *medical insurance*, either you or the doctor or supplier submits the claim for payment. Medicare will send you a notice of the decision made on the claim. If you disagree with the decision, you can ask the Medicare carrier that handled the claim to review it. Then, if you still disagree with the decision and if the amount Medicare would pay if the appeal were fully allowed is $100 or more, you can request a hearing by the carrier. To reach the $100 amount, you can count other claims that you have had reviewed within the past 6 months. The decision of the carrier hearing officer is final. Under the medical insurance

program, the law does not provide for Federal court review.

The notice you receive from Medicare which tells you of the decision made on your claim will also tell you exactly what appeal steps you can take. If you ever need more information about your right of appeal and how to request it, call any Social Security office, the Medicare intermediary or carrier, or the Peer Review Organization in your State.

IF YOU ARE A MEMBER OF A PREPAYMENT PLAN

Prepayment plans make health services available to their members in a special way. Generally, each member pays regular premiums to the plan. The member can then receive health services the plan provides, whenever he or she needs them, without additional charges. In some plans, small charges are made for certain services, such as drugs or home visits.

Many prepayment plans have made arrangements with Medicare to receive direct payments for services they furnish which are covered under the medical insurance part of Medicare. Some prepayment plans have contracts with Medicare as Health Maintenance Organizations or Competitive Medical Plans, and can receive direct payment for services covered by either hospital insurance or medical insurance.

If you are a member of a prepayment plan, ask the people in charge of the plan what arrangements have been made for Medicare payments. Find out, too, what you should do when you get health services that are not provided by the plan.

If you want to know whether there are any Health Maintenance Organizations or other types of prepayment plans in your area, call any Social Security office.

WHAT MEDICARE DOES NOT COVER

This alphabetical list shows most of the major services and supplies that Medicare usually does not pay for. However, some of these items can be covered by Medicare under certain conditions described on the pages indicated.

Acupuncture

Chiropractic services (See page 30)

Christian Science practitioners' services

Cosmetic surgery (See page 29)

Custodial care

Dental care (See page 31)

Drugs and medicines you buy yourself with or without a doctor's prescription (See table on page 21)

Eyeglasses and eye examinations for prescribing, fitting, or changing eyeglasses (See page 38)

Foot care that is routine (See page 30)

Foreign health care (See page 15)

Hearing aids and hearing examinations for prescribing, fitting, or changing hearing aids

Homemaker services (See table on page 21)

Immunizations except pneumococcal vaccinations or immunizations required because of an injury or immediate risk of infection

Injections which can be self-administered, such as insulin

Meals delivered to your home

Naturopaths' services

Nursing care on full-time basis in your home

Orthopedic shoes unless they are part of a leg brace and are included in the orthopedist's charge

Personal convenience items that you request such as a phone, radio, or television in your room at a hospital or skilled nursing facility

Physical examinations that are routine and tests directly related to such examinations

Private duty nurses

Private room (See table on page 11 or 19)

Services performed by immediate relatives or members of your household

Services which are not reasonable and necessary

Services payable by any of the following:

- Workers' Compensation (including black lung benefits)
- Automobile or liability insurance
- Employer group health plans for employees and their spouses age 65 through 69
- Employer group health plans for people entitled to Medicare solely on the basis of end stage renal disease
- Another government program

Services for which neither the patient nor another party on his or her behalf has a legal obligation to pay

Supportive devices for the feet

HOW TO GET THE PART OF MEDICARE YOU DO NOT HAVE

If you have Medicare hospital insurance but do not have the medical insurance part of Medicare, you can sign up for medical insurance during a general enrollment period. A general enrollment period is held January 1 through March 31 each year. If you enroll during a general enrollment period, your monthly premium will be 10 percent higher than the basic premium* for each 12-month period you could have had medical insurance but were not enrolled. Also, your protection will not start until July 1 of the year you enroll.

Some individuals 65 or older have Medicare medical insurance, but do not meet the requirements for premium - free hospital insurance. If you are in this category, you can get hospital insurance by paying a monthly premium. You can sign up for hospital insurance during a general enrollment period—January 1 through March 31 each year. If you enroll during a general enrollment period, your monthly premium will be 10 percent higher than the basic premium** for each 12-month period you could have had hospital insurance but were not enrolled. Also, your protection will not begin until July 1 of the year you enroll.

***Medical insurance premium**

The basic medical insurance premium is $15.50 a month through December 31, 1986. This amount may change next January 1.

****Hospital insurance premium**

The basic hospital insurance premium is $214 a month through December 31, 1986. This amount changes each January 1. This premium applies *only* to persons who are not otherwise entitled to hospital insurance.

Your Social Security office can answer any questions you may have on how to get the part of Medicare you do not have now.

EVENTS THAT CAN END YOUR MEDICARE PROTECTION

If you are 65 or older

If you have Medicare hospital insurance because you are entitled to Social Security benefits on your husband's or wife's work record, your protection will end if your entitlement to benefits ends. If you have hospital insurance as the spouse of a Federal employee, your protection will end if you and your spouse divorce before your marriage has lasted 10 years. If you have hospital insurance based on your own Social Security work record or on your own Federal employment, your protection will continue as long as you live.

Your medical insurance protection will stop if your premiums are not paid or if you voluntarily cancel. If you are thinking about cancelling your medical insurance, remember that you may not be able to get private insurance that offers the same protection. Also, if you cancel your medical insurance and then later decide to re-enroll, your premium will be higher and your protection will not begin again until July 1 of the year you re-enroll.

If you are buying hospital insurance, you will lose it if you cancel your medical insurance. People who buy hospital insurance *must* enroll and pay the premium for medical insurance. But, you can cancel your hospital insurance and still continue your medical insurance.

If you want more information about cancelling your Medicare protection, get in touch with any Social Security office.

If you are disabled

If you have Medicare because you are disabled and entitled to Social Security disability checks, your protection will end if your disability benefits stop because you recover from your disability before you are 65. If you go to work but are still disabled, your Medicare protection may continue for up to 48 months after you begin working.

If you are disabled and entitled to Medicare on the basis of your own or someone else's Federal employment, your Medicare protection will end if you recover from your disability before you reach 65. If you go to work but are still disabled, your Medicare protection may continue for up to 48 months.

If you ever want to cancel your medical insurance, call any Social Security office.

If you have permanent kidney failure

If you have Medicare because of permanent kidney failure, your protection will end 12 months after the month maintenance dialysis treatment stops or 36 months after the month you have a kidney transplant.

Your medical insurance protection could stop before that for failure to pay premiums or if you decide to cancel. Call any Social Security office if you ever want to cancel your medical insurance protection.

OTHER HEALTH INSURANCE PROTECTION

Buying supplemental health insurance

Medicare provides basic protection against the high cost of health care, but it will not pay all of your medical expenses. For this reason, many private insurance companies sell insurance to supplement Medicare. The Federal Government does *not* sell or service such insurance.

If you are thinking about buying private insurance to supplement your Medicare protection, please shop carefully. Contact different companies and compare their policies. Make certain a policy does not simply duplicate your Medicare coverage.

If you want help in deciding whether to buy private supplementary insurance, call any Social Security office and ask for the pamphlet, *Guide to Health Insurance for People with Medicare*. This free pamphlet, published by the Health Care Financing Administration, describes the various kinds of supplemental insurance available and explains how they relate to Medicare coverage.

If you work after age 65

Employers with 20 or more employees are required to offer workers and their spouses age 65 through 69 the same health benefits that are offered to younger workers. And, the employer's health plan must be offered to older workers under the same conditions that it's offered to younger employees.

If you continue working after 65, you have the option to accept or reject your employer's health plan. If you accept it, Medicare will become the secondary health insurance payer. But if you reject your

employer's health plan, Medicare will remain the primary health insurance payer.

For more information, contact your employer or ask any Social Security office for a free copy of *Medicare and Employer Health Plans*.

HOW TO SUBMIT MEDICAL INSURANCE CLAIMS

A *Patient's Request for Medicare Payment* form, also called Form 1490S, must be submitted to the Medicare carrier in order for medical insurance to pay for covered services of doctors and suppliers. All Social Security offices and Medicare carriers, and most doctors' offices, have copies of the form. Instructions on how to fill it out are on the back of the form.

If the doctor or supplier is Medicare-participating or uses the assignment method of payment, he or she submits the claim.

If the doctor or supplier does not accept assignment, you submit the claim, using the *Patient's Request for Medicare Payment* form. Complete and sign the form *and* attach itemized bills for the services you received.

An itemized bill *must* show (1) the date you received the services, (2) the place where you received the services, (3) a description of the services, (4) the charge for each service, (5) the doctor or supplier who provided the services, and (6) your name *and* your health insurance claim number, *including* the letter at the end of the number. If the bill doesn't include all of this information, your payment will be delayed. It is also helpful if the nature of your illness (diagnosis)

is shown on the bill. If you are submitting a claim for the rental or purchase of durable medical equipment, you must include the bill from the supplier *and* the doctor's prescription. The prescription must show the equipment you need, the medical reason for the need, and estimate of how long the equipment will be medically necessary.

You may submit a number of itemized bills with a single *Patient's Request for Medicare Payment* form. It doesn't matter whether all the bills are from one doctor or supplier or from different people who gave you services. You can send in the bills either before or after you pay them.

Before any medical payment can be made, your record must show that you have met the deductible. So, as soon as your bills come to $75 in 1986, send them to your Medicare carrier with a *Patient's Request for Medicare Payment* form. Page 55 will tell you where to send your claim. Once you have met the $75 deductible, we suggest that you send in your future bills for covered services as soon as you get them so that Medicare payment can be made promptly.

If all your medical bills for the year amount to less than $75, medical insurance cannot pay any part of your bills for the year.

It's a good idea to keep a record of your medical insurance claim in case you ever want to inquire about it. Before you send in a claim, write down the date you mail it, the services you received, the date and charge for each service, and the name of the person who provided each service.

Claims for a person who dies

When someone who has Medicare dies, any hospital insurance payments due will be paid directly to the hospital, skilled nursing facility, home health agency or hospice that provided covered services.

For services covered under medical insurance, some special rules apply, depending on whether or not the doctor's or supplier's bill has been paid.

If the bill was paid by the patient or with funds from the patient's estate, payment will be made either to the estate representative or to a surviving member of the patient's immediate family. If someone other than the patient paid the bill, payment may be made to that person.

If the bill has not been paid and the doctor or supplier does not accept assignment, the medical insurance payment can be made to the person who has a legal obligation to pay the bill for the deceased patient. The person can claim the medical insurance payment either before or after paying the bill.

The Medicare carrier or any Social Security office can provide additional information about how to claim a medical insurance payment after a patient dies.

Time limits for submitting claims

Under the law, there are some time limits for submitting medical insurance claims. For medical insurance to make payments on your claims, you must send in your claims within these time limits. You always have at least 15 months to submit claims. The table below tells you exactly what the time limits are.

For services you receive between	Your claim must be submitted by
October 1, 1984, and September 30, 1985	December 31, 1986
October 1, 1985, and September 30, 1986	December 31, 1987
October 1, 1986, and September 30, 1987	December 31, 1988

WHERE TO SEND YOUR MEDICAL INSURANCE CLAIMS

The list beginning on the next page gives the names and addresses of the Medicare carriers selected to handle claims for an entire State. But some carriers handle claims for only part of a State. To find out where to send your medical insurance claim, look in the list for the State *where you received the services.* Under the name of the State, you will find the name of the carrier that will handle your claim. If there is more than one carrier in the State, look for the *county* where you received services to find the carrier that will handle your claim. (See page 52 to find out how to submit medical insurance claims.)

If you are not sure where to send your first claim and happen to send it to the wrong office, your claim will be sent on to the right place.

Whenever you send in a claim, be sure to include the word "Medicare" in the carrier's address on the envelope. Also, be sure to put *your* return address and a stamp on the envelope.

After you make a claim, the carrier will usually send you another *Patient's Request for Medicare Payment* form for your next claim. The form will usually show the carrier's name and address in the top right-hand corner. If you ever need to file a medical insurance claim and don't have a claim form, you can get one by phoning the Medicare carrier or a Social Security office.

Note: If you are entitled to Medicare under the railroad retirement system, send your medical insurance claims to The Travelers Insurance Company office which serves your region. Regional offices of The Travelers are listed in Your Medicare Handbook for Railroad Retirement Beneficiaries, *which is available at any railroad retirement office.*

Alabama
Medicare Blue Cross-Blue Shield of Alabama
P.O. Box C-140
Birmingham, Alabama, 35283

Alaska
Medicare
Aetna Life & Casualty
200 S.W. Market
P.O. Box 1997
Portland, Oregon 97207

Arizona
Medicare
Aetna Life & Casualty
I0000 N. 31st Avenue
P.O. Box 37200
Phoenix, Arizona 85069

Arkansas
Medicare
Arkansas Blue Cross and Blue Shield
P.O. Box 1418
Little Rock, Arkansas 72203

California
Counties of: Los Angeles, Orange, San Diego, Ventura, Imperial, San Luis Obispo, Santa Barbara
Medicare
Transamerica Occidental Life Insurance Co.
Box 54905
Terminal Annex
Los Angeles, California 90054

Rest of State:
Medicare Claims Dept.
Blue Shield of California
Chico, California 95976

Colorado
Medicare
Blue Shield of Colorado
700 Broadway
Denver, Colorado 80273

Connecticut
Medicare
Connecticut General Life
Insurance Co.
100 Barnes Road, North
P.O. Box 5005
Wallingford, Connecticut
06493

Delaware
Medicare
Pennsylvania Blue Shield
P.O. Box 65
Camp Hill, Pennsylvania
17011

District of Columbia
Medicare
Pennsylvania Blue Shield
P.O. Box 100
Camp Hill, Pennsylvania
17011

Florida
Medicare
Blue Shield of Florida,
Inc.
P.O. Box 2525
Jacksonville, Florida
32231

Georgia
The Prudential Insurance
Co. of America
Medicare Part B
P.O. Box 546
Buford, Georgia 30518

Hawaii
Medicare
Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812

Idaho
Medicare
The Equitable Life
Assurance Society
P.O. Box 8048
Boise, Idaho 83707

Illinois
Medicare Claims
Blue Cross and Blue
Shield of Illinois
P.O. Box 4422
Marion, Illinois 62959

Indiana
Medicare Part B
Associated Insurance
Companies, Inc.
P.O. Box 7073
Indianapolis, Indiana
46204

Iowa
Medicare
Blue Shield of Iowa
636 Grand
Des Moines, Iowa 50307

Kansas
Counties of: Johnson,
Wyandotte
Medicare
Blue Shield of Kansas
City
P.O. Box 169
Kansas City, Missouri
64141

Rest of State:
Medicare
Blue Shield of Kansas
P.O. Box 239
Topeka, Kansas 66601

Kentucky
Medicare–Part B
Blue Cross and Blue
Shield of Kentucky
1218 Harrodsburg Road
Lexington, Kentucky
40504

Louisiana
Blue Cross and Blue
Shield of Louisiana
7700 GSRI Ave.
Baton Rouge, Louisiana
70820

Maine
Medicare
Blue Shield of
Massachusetts/Tri-State
P.O. Box 1010
Biddeford, Maine 04005

Maryland
Counties of: Montgomery, Prince Georges
Medicare
Pennsylvania Blue Shield
P.O. Box 100
Camp Hill, Pennsylvania
17011

Rest of State:
Maryland Blue Shield, Inc.
700 E. Joppa Road
Towson, Maryland 21204

Massachusetts
Medicare
Blue Shield of
Massachusetts, Inc.
55 Accord Park Drive
Rockland, Massachusetts
02371

Michigan
Medicare
Part B Michigan
Blue Cross/Blue Shield
P.O. Box 2201
Detroit, Michigan 48231

Minnesota
Counties of: Anoka, Dakota, Filmore, Goodhue, Hennepin, Houston, Olmstead, Ramsey, Wabasha, Washington, Winona
Medicare
The Travelers Insurance
Company
8120 Penn Avenue, South
Bloomington, Minnesota
55431

Rest of State:
Medicare
Blue Shield of Minnesota
P.O. Box 43357
St. Paul, Minnesota
55164

Mississippi
Medicare
The Travelers Insurance
Co.
P.O. Box 22545
Jackson, Mississippi
39205

Missouri
Counties of: Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair, Saline, Vernon, Worth
Medicare
Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Rest of State:
Medicare
General American Life Insurance Co.
P.O. Box 505
St. Louis, Missouri 63166

Montana
Medicare
Montana Physicians' Service
P.O. Box 4310
Helena, Montana 59601

Nebraska
Medicare
Blue Shield of Iowa
P.O. Box 10479
Des Moines, Iowa 50306

Nevada
Medicare
Aetna Life & Casualty
P.O. Box 37230
Phoenix, Arizona 85069

New Hampshire
Medicare
Blue Shield
of Massachusetts/Tri-State
P.O. Box 1010
Biddeford, Maine 04005

New Jersey
Medicare
The Prudential Insurance Co. of America
P.O. Box 3000
Linwood, New Jersey 08221

New Mexico
Medicare
The Equitable Life
Assurance Society
P.O. Box 3070,
Station D
Albuquerque,
New Mexico 87190

New York
Counties of: Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester
Medicare
Blue Cross-Blue Shield of
Greater New York
P.O. Box 458
Murray Hill Station
New York, New York
10016

County of: Queens
Medicare
Group Health, Inc.
P.O. Box A966,
Times Square Station
New York, New York
10036

Rest of State:
Medicare
Blue Shield of Western
New York
P.O. Box 600
Binghamton, New York
13902 0600

North Carolina
The Prudential Insurance
Co. of America
Medicare B Division
P.O. Box 2126
High Point, North
Carolina 27261

North Dakota
Medicare
Blue Shield of North
Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota
58121

Ohio
Medicare
Nationwide Mutual In-
surance Co.
P.O. Box 57
Columbus, Ohio 43216

Oklahoma
Medicare
Aetna Life & Casualty
701 N.W. 63rd St.
Oklahoma City,
Oklahoma 73116

Oregon
Medicare
Aetna Life & Casualty
200 S.W. Market St.
P.O. Box 1997
Portland, Oregon 97207

Pennsylvania
Medicare
Pennsylvania Blue Shield
Box 65 Blue Shield Bldg.
Camp Hill, Pennsylvania
17011

Rhode Island
Medicare
Blue Shield of Rhode
Island
444 Westminster Mall
Providence, Rhode Island
02901

South Carolina
Medicare
Blue Cross & Blue Shield
of South Carolina
Claims Processing Unit
I-20 at Alpine Road
Drawer F
Columbia, South Carolina
29260-9987

South Dakota
Medicare
Blue Shield of North
Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota
58121

Tennessee
Medicare
The Equitable Life
Assurance Society
P.O. Box 1465
Nashville, Tennessee
37202

Texas
Medicare
Blue Cross & Blue Shiel
of Texas, Inc.
P.O. Box 660031
Dallas, Texas 75266-003

Utah
Medicare
Blue Cross and Blue
Shield of Utah
P.O. Box 30270
2455 Parley's Way
Salt Lake City, Utah
84130 0270

Vermont
Medicare
Blue Shield
of Massachusetts/Tri-State
P.O. Box i010
Biddeford, Maine 04005

Virginia
Counties of: Arlington, Fairfax
Cities of: Alexandria, Falls Church, Fairfax
Medicare
Pennsylvania Blue Shield
P.O. Box 100
Camp Hill, Pennsylvania 17011

Rest of State:
Medicare
The Travelers Insurance Co.
P.O. Box 26463
Richmond, Virginia 23261

Washington
Medicare
Washington Physicians' Service
Mail to your local
Medical Service Bureau
If you do not know which bureau handles your claim, mail to:
Medicare Washington
Physicians' Service
4th and Battery Bldg.,
6th floor
2401 4th Avenue
Seattle, Washington
98121

West Virginia
Medicare
Nationwide Mutual Insurance Co.
P.O. Box 57
Columbus, Ohio 43216

Wisconsin
Medicare
WPS
Box 1787
Madison, Wisconsin
53708

Wyoming
Medicare
The Equitable Life
Assurance Society
P.O. Box 628
Cheyenne, Wyoming
82001

American Samoa
Medicare
Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812

Guam
Medicare
Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812

Puerto Rico
Medicare
Seguros De Servicio De
Salud De Puerto Rico
Call Box MCA
Hato Rey, Puerto Rico
00918

Virgin Islands
Medicare
Seguros De Servicio De
Salud De Puerto Rico
Call Box MCA
Hato Rey, Puerto Rico
00918

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